TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgical Hospital

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-3563-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services… Our claim for medical services provided was mailed to the insurance carrier on 01/12/2015. As of 06-24-2015 no response has been received regarding payment or denial. Numerous attempts have been made to contact the carrier to obtain the status of payment without any calls being returned."

Amount in Dispute: $1,251.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have researched the DOS/Claim in question. There is no record of a hospital bill in RisxFacs attached to this claim record. Nothing rejected. We have not received the bill from the provider to process. No supporting documentation received that this bill was ever submitted to Gallagher Bassett Services for payment."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2014	Outpatient Hospital Services	$1,251.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Neither party provided an explanation of benefits related to the dates of service in dispute.

Issues

1. Did the requestor provide evidence that an EOB was requested?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider… or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for these disputed dates of service. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (K).
2. No additional payment can be recommended as no evidence was found to support the submission of the claim and/or a request for an explanation of benefits was made.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.